March 2011

Health Care Reform Issues:
Patient Centered Medical Home & Meaningful Use

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Smarter benefits. Better health.

South Carolina

Today's Goals

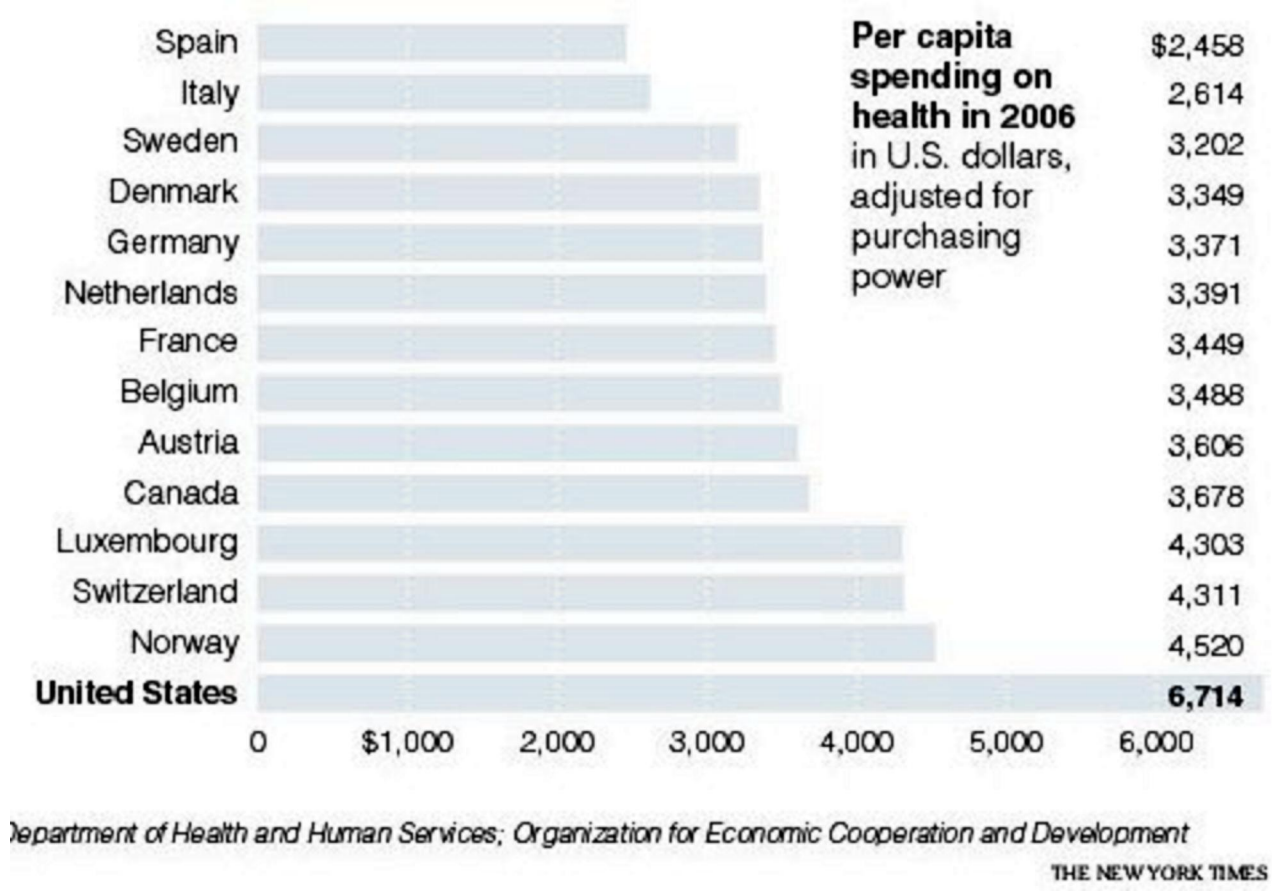
- Explore existing models for patient centered medical homes in South Carolina.
- Review clinical and financial outcomes of BlueCross BlueShield South Carolina patient centered medical home pilots.
- Review federal meaningful use requirements and how the patient centered medical home model can be used to meet them.
- At the conclusion of the talk, the student will be able to name two ways the patient centered medical home model can help practices meet federal meaningful use requirements.

[Why do we need innovation?]

[Letôs take a look
at our current health care system]

Why is our healthcare system so expensive and yet so broken?

Average health spend per capita ($US PPP)



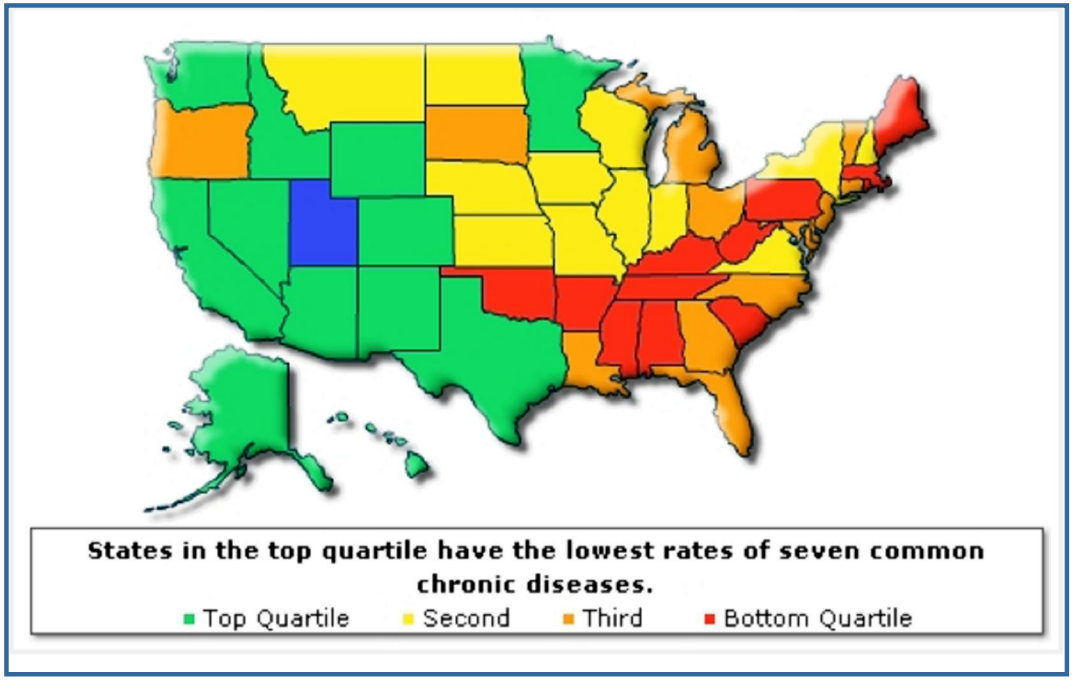
Increasing prevalence of chronic diseases with health care system ill-prepared to meet patient needs

- **50% of Americans** live with one or more chronic conditions
- Only **54%** of chronic adult patients receive recommended care
- Over **60%** of patients are non-compliant
- Experts estimate **20-50%** of U.S. health care spending produces no benefit to patients é and potential harm
- Health costs in the United States are **growing faster** than employee wages and the economy at large.

Burden of Chronic Disease In South Carolina

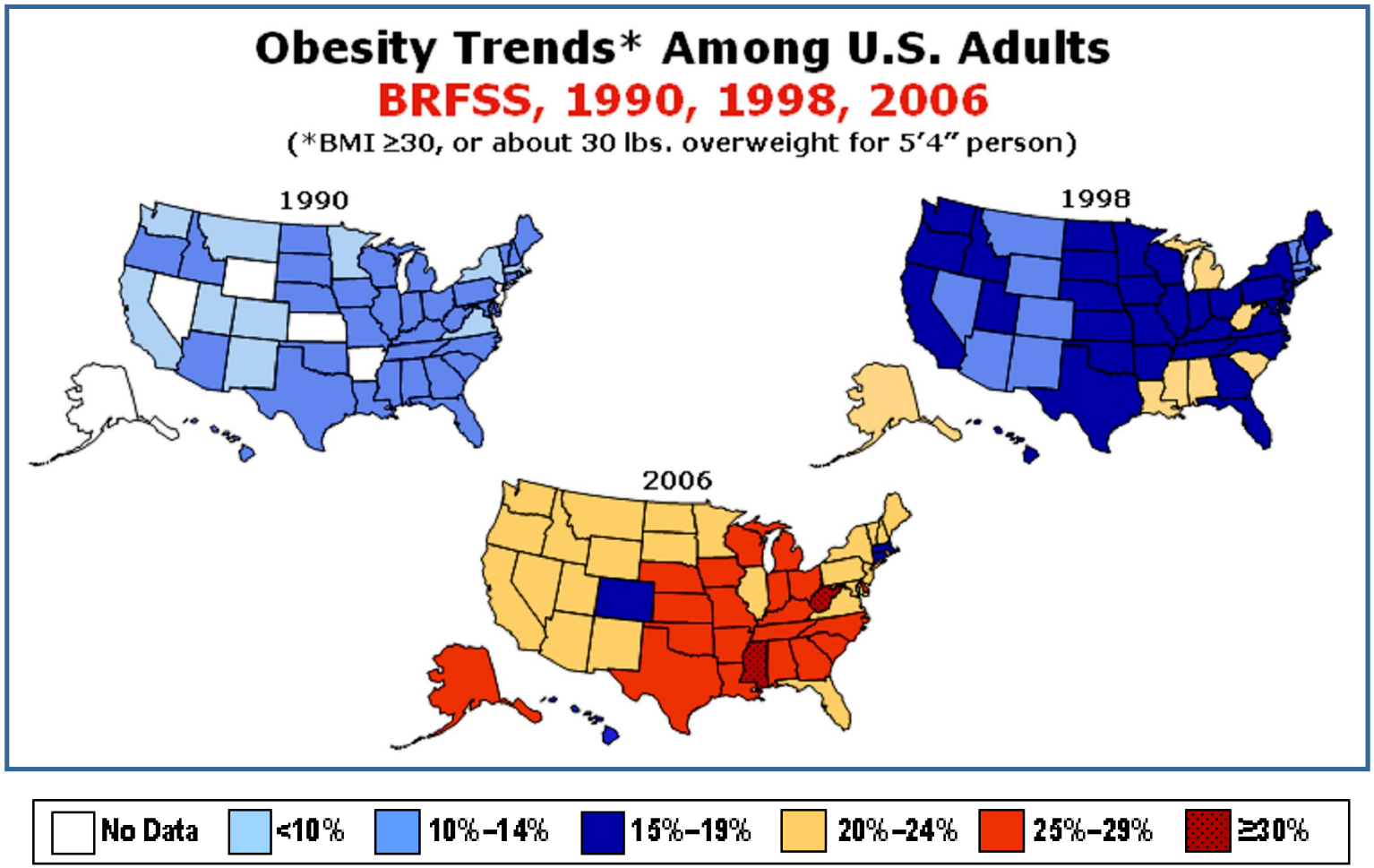
Milken Institute Chronic Disease Index
South Carolina Index Rank - **39** Composite Score - **68.76**

Reported Cases of Common Chronic Diseases 2003
(As percent of population)
Cancers: 163,923 (4.0%)
Diabetes: 241,624 (5.8%)
Heart Disease: 273,438 (6.6%)
Hypertension: 590,800 (14.2%)
Stroke: 42,046 (1.0%)
Mental Disorders: 564,372 (13.6%)
Pulmonary Conditions: 639,809 (15.4%)



Source: ***An UnHealthy America: The Economic Burden of Chronic Disease,*** **Milken Institute, 2007**

Obesity Trends in South Carolina



Source: CDC Behavioral Risk Factor Surveillance System.

Patient-Centered Medical Home Pilots

Patient-Centered Medical Home

- Innovative care redesign: Population based and patient focused
- Quality based incentives to drive overall lower care cost
- Reimbursement redesign to align incentives
- Transparent and measurable outcomes for employers/members

Medical Homes: Cost Benefit

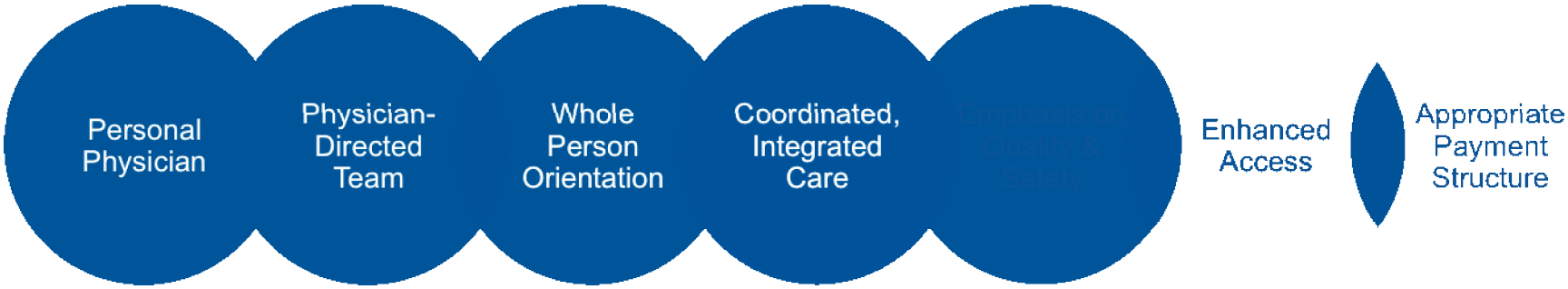
- Care Delivered by a Primary Care Physician in a Medical Home is **consistently associated** with:
  - Better Outcomes
  - Reduced Mortality
  - Fewer Hospital Admissions for Chronic Diseases
  - Lower Utilization
  - Improved Patient Compliance

www.pcpcc.net/content/evidence

Patient-Centered Medical Home

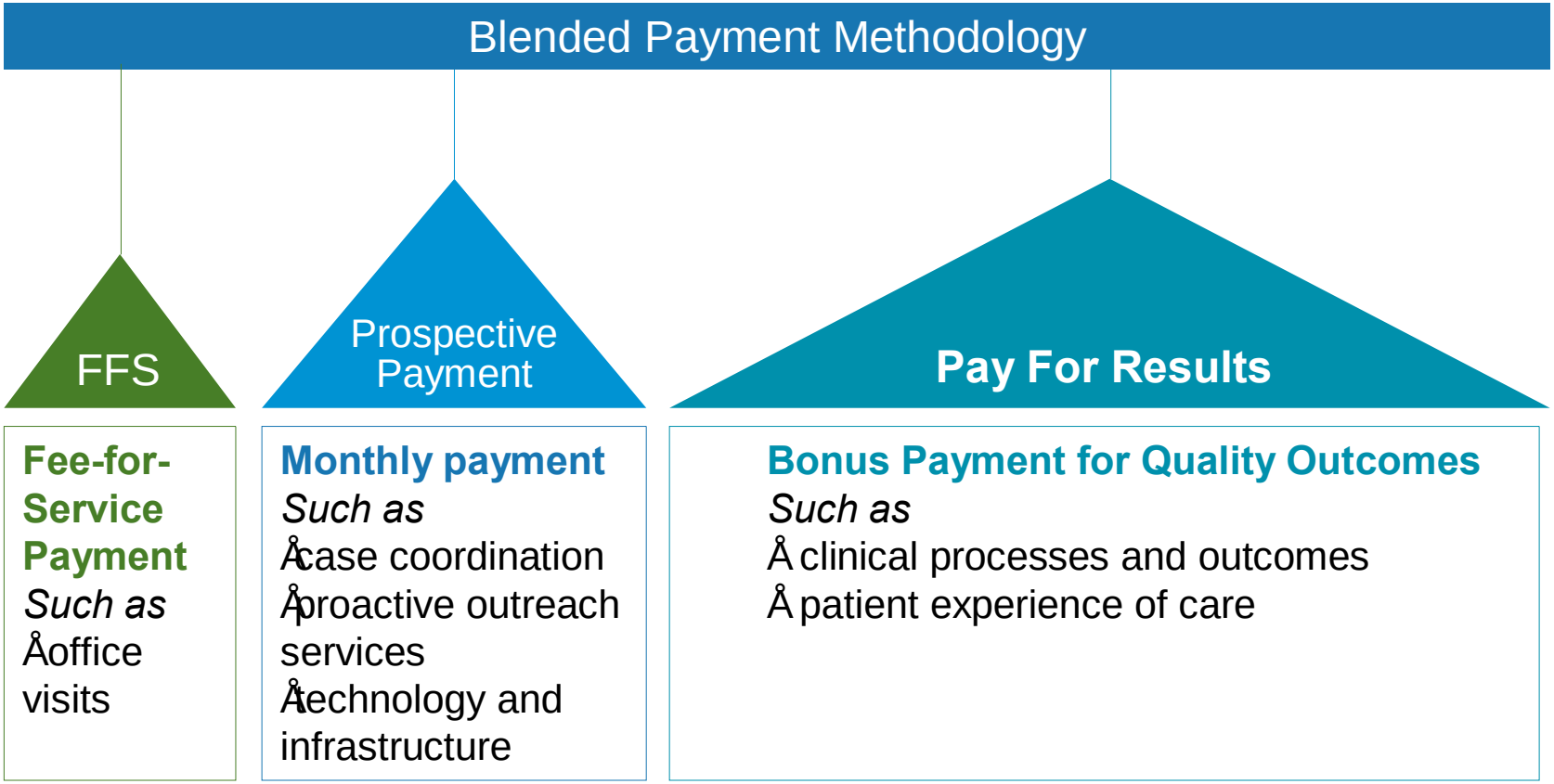
What is it?

7 Joint Principles



Source: ñJoint Principles of a Patient-Centered Medical Home,òAdopted March 2007 by: American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association

Cornerstone for Success: Reimbursement Methodology



NCQA PPC-PCMH Measurement Tool

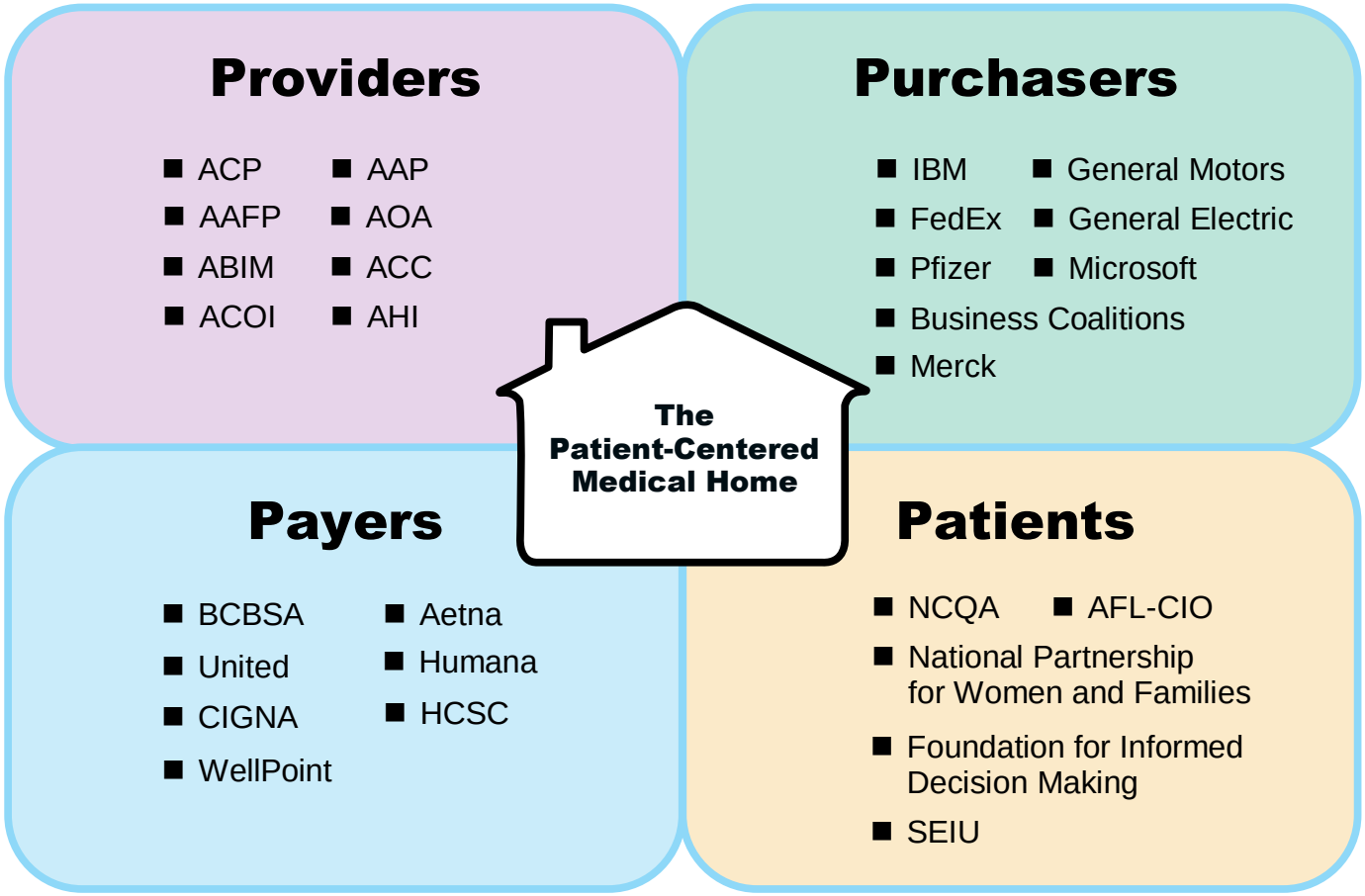
Level 1 Medical Home	Level 2 Medical Home	Level 3 Medical Home

NCQA PCMH-PPC

- Access and communication
- Patient tracking and registry functions
- Care management
- Patient self-management support
- Test tracking and follow-up
- Referral tracking
- Performance reporting and improvement
- Electronic prescribing
- Advanced electronic communication

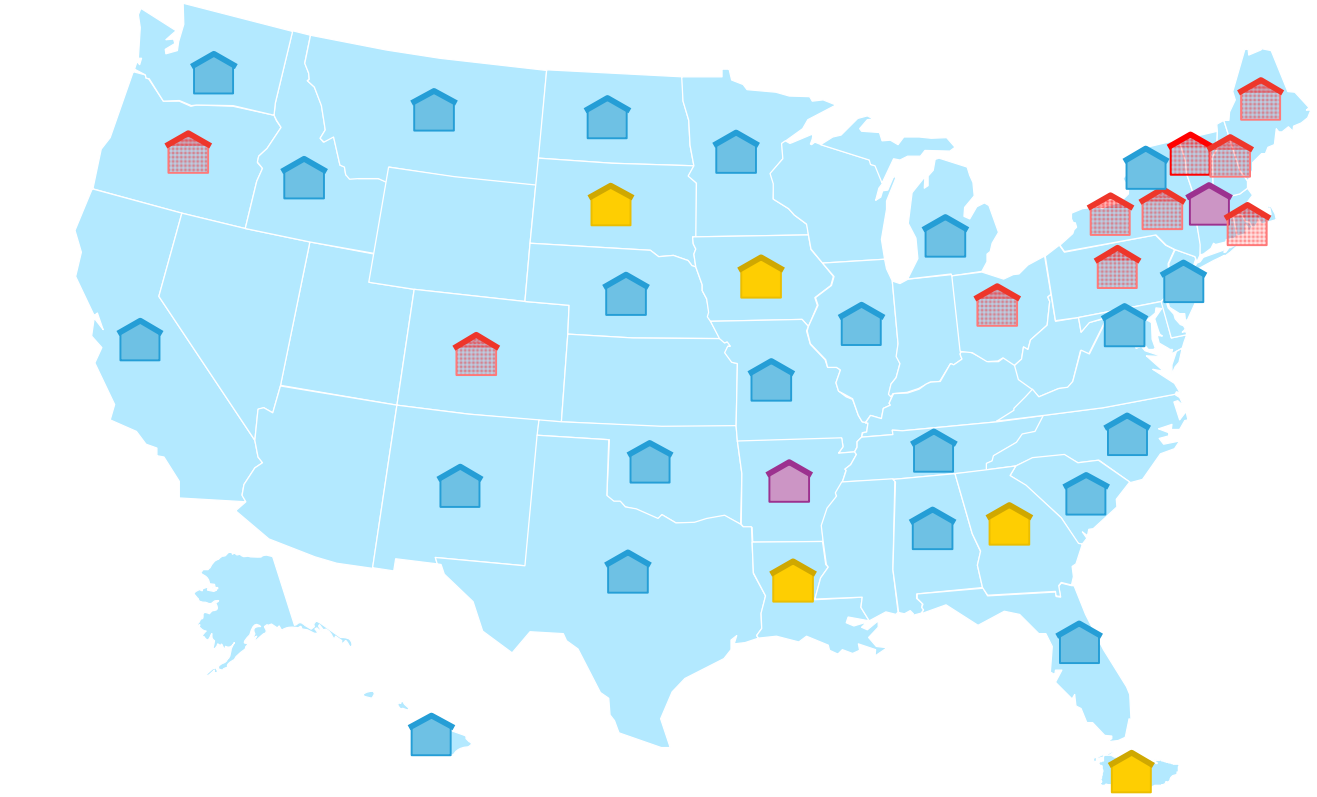
The Patient-Centered Primary Care Collaborative

Examples of Broad Stakeholder Support & Participation



Patient-Centered Medical Home Demonstrations

Blue Cross Blue Shield Plan Pilots (as of January 2011)



Harvard Medical School Analysis of Seven PCMH Pilot Programs

Pilot	# of Patients	Population	Incentives	Results		
				Hospitalization reduction (%)	ER visit reduction (%)	Total savings per patient
Colorado Medical Homes for Children	10,781	Medicaid CHP+	Pay for Performance (P4P)	18%	NA	$169-530
Community Care of North Carolina	> 1 million	Medicaid	Per Member Per Month (PMPM) payment	40%	16%	$516
Geisinger (ProvenHealthNavigator)	TBD	Medicare Advantage	P4P; PMPM payment; shared savings	15%	NA	NA
Group Health Cooperative	9,200	All	TBD	11%	29%	$71
Intermountain Health Care (Care Management Plus)	4,700	Chronic disease	P4P	4.8-19.2%	0-7.3%	$640
MeritCare Health System and Blue Cross Blue Shield of North Dakota	192	Diabetes	PMPM payment; shared savings	6%	24%	$530
Vermont BluePrint for Health	60,000	All	PMPM payment	11%	12%	$215

Adapted from Fields D, Leshen E, and Patel K. "Driving quality gains and cost savings through adoption of medical homes," *Health Affairs*, May 2010; 29(5): 819-826. Appendix Exhibit 1.

Pilot Program Overview

Collaborative Partnership with Palmetto Primary Care Physicians

The Facts

- Diabetes is increasing at epidemic proportions
- 20.8 million people in U.S. have diabetes
- Two-thirds of people with diabetes die of heart disease or stroke
- Focus on disease progression reduces cxôs
- Patient self-management is critical

The Partners

- Palmetto Primary Care Physicians
  - » 20 sites, 55 providers
  - » Berkeley, Dorchester, and Charleston counties
- Extensive Patient Services and Support
  - » Electronic Medical Records
  - » Triage Services
    - Medical advice 24/7
    - Onsite RNs
- Extended Care Clinic
  - » Open evenings and weekends
  - » Onsite physician
- Comprehensive Diagnostic Services

While reform percolates

S.C. Blues, docs team up for medical home pilot

As the nation looks to transform healthcare from delivering too much care to consistently delivering higher quality, high-value care, Blue Cross and Blue Shield of South Carolina isn't waiting for a healthcare reform law.

We are working with the provider community to look at things differently. A great example is a patient-centered medical home pilot with Palmetto Primary Care Physicians in three counties in the Charleston, S.C., area.

A yearlong collaboration that started in April, the pilot focuses on our diabetic members who are patients of PPCP. More than 1,500 people are enrolled.

Payment is transformed to align with delivering quality care. In addition to traditional fee-for-service payments, a per-participant, per-month fee is added to allow the practice to hire case managers to coordinate patients' care plans, cover physician time to participate in case management meetings and hire staff to conduct on-site education.

The PPCP case managers integrate with Blue Cross disease managers to coordinate use of insurance benefits and disease-management programs. An electronic link from the disease-manager coaches to the practice's electronic health record speeds communication with providers and aligns communication with the physician's treatment plan.

Blue Cross started the project by mailing introductory information to eligible members. PPCP hired case managers who contacted eligible patients by phone to further explain the program, gather baseline health data and encourage them to use an online portal. The portal contains tools to manage their disease and an option for "e-visits" with a physician, so continuity of care can be maintained when patients are traveling.

There is no copayment or extra charge to the patients, and very few opted out.

The case managers are now following each patient through their care continuum as they aim to reduce gaps in care and address lifestyle issues. They perform outreach, such as registering patients for diabetic education, scheduling appointments with specialists, providing discount vouchers for medications, offering discounted memberships to local gyms and monitoring quality processes and outcomes measures.

At the end of the pilot's year, if improvement in quality measures has been achieved, we will reward PPCP with a bonus.

There have been challenges. The case managers reported that most people never read the first Blue Cross mailing, and many had a hard time understanding the concept but were still willing to participate because there was no charge. It also took longer than expected to reach each patient by phone, even with night and weekend calls. Setting up the online portal and establishing links with Blue Cross and local emergency rooms was technologically challenging.

But early successes were noted. A case manager called a patient and found he had just lost his job. He had little feeling in his feet and had an infected toe but did not plan to address the problem because of his high-deductible insurance plan. The case manager and Blue Cross' diabetic educator coordinated to provide a bridge supply of medication and test strips, education materials, drug copay assistance and an office visit. The patient later reported that his finances had improved, and he "never felt better."

Another patient was confused about glucose levels and shocked to find her levels were high at a recent appointment. After conversations with the case manager and a Blue Cross certified diabetes educator, the patient attended a diabetic education class and described it as "fantastic and enlightening" and said she is "looking at everything differently."

The goal of this pilot is for health plans and physicians to work together to reduce the disconnects in healthcare, improve quality of life for patients, create tighter relationships and better communication and add a focus on measurement of quality and continuous improvement of clinical outcomes.

We believe this could become a model for South Carolina.

Laura Long, a physician, is vice president of clinical quality and health management at Blue Cross and Blue Shield of South Carolina, Columbia.

Palmetto Primary Care Physicians Collaboration
April 2009 – March 2010 (Pilot Year 1)

The Goal

Improve outcomes for diabetic members through patient education, self-management, lifestyle and daily routine changes

Patient Benefits

- Medical home with NCQA-accredited physicians
- Case management support/team based approach
- Collaboration with plan health coaches and integrated electronic connection to disease management programs
- Onsite wellness and education classes with materials
- Online patient portal with personal health record
- e-Visits
- Enhanced office access (evening and weekend hours)
- Free uploadable glucometers
- Integrated electronic connection to local ERs

The BlueCross BlueShield of South Carolina Experience: Patient Centered Medical Home

Initial Pilot First Year Outcomes

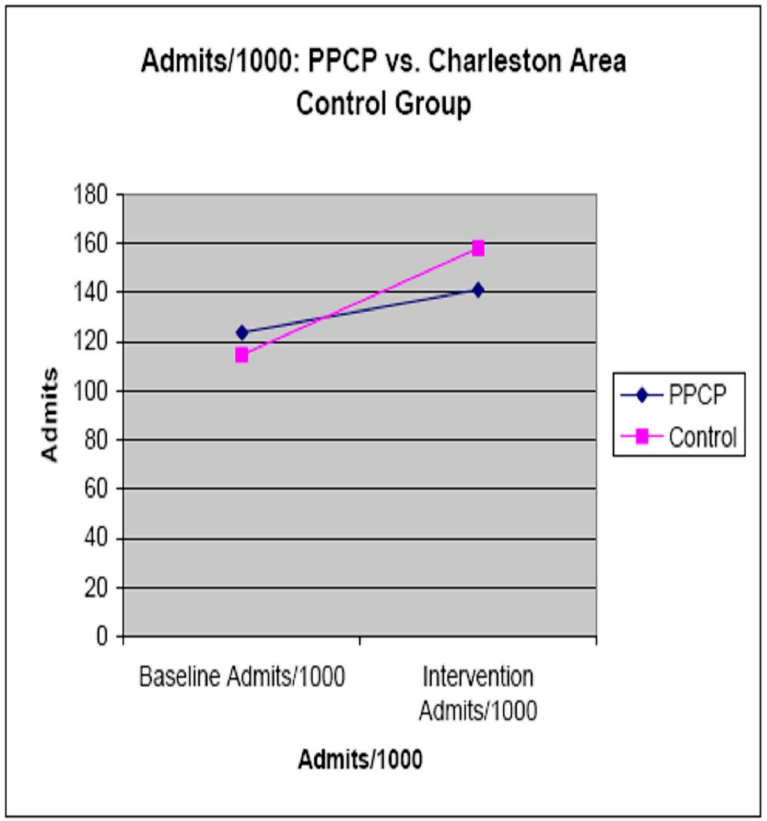
Medical Home Pilot Participants*

Measure	Baseline	Outcome	% Change	Improvement
% of members with an HbA1C test	80%	83.6%	4.5%	✓
% of members with an HbA1c test < 8	76.6%	79%	3.1%	✓
% of members with blood pressure reading	98.1%	92.3%	(5.9%)	
% of members with blood pressure managed to less than 130/80	59.1%	56.5%	(4.3%)	
% of members with LDL test	77.8%	75.8%	(2.6%)	
% of members with LDL test < 100	47.4%	58%	22.3%	✓
% of members with mAB test	37.3%	47.4%	27.1%	✓
% of members with annual eye exam	27.6%	32.8%	19.1%	✓
% of members with BMI measurements	87.3%	76.8%	(12%)	
Net % with improved BMI		31.6%		✓

*Continuously enrolled participants. Outcomes measured 4/1/09 – 3/31/10

Pilot Group vs. Charleston Area Control Group

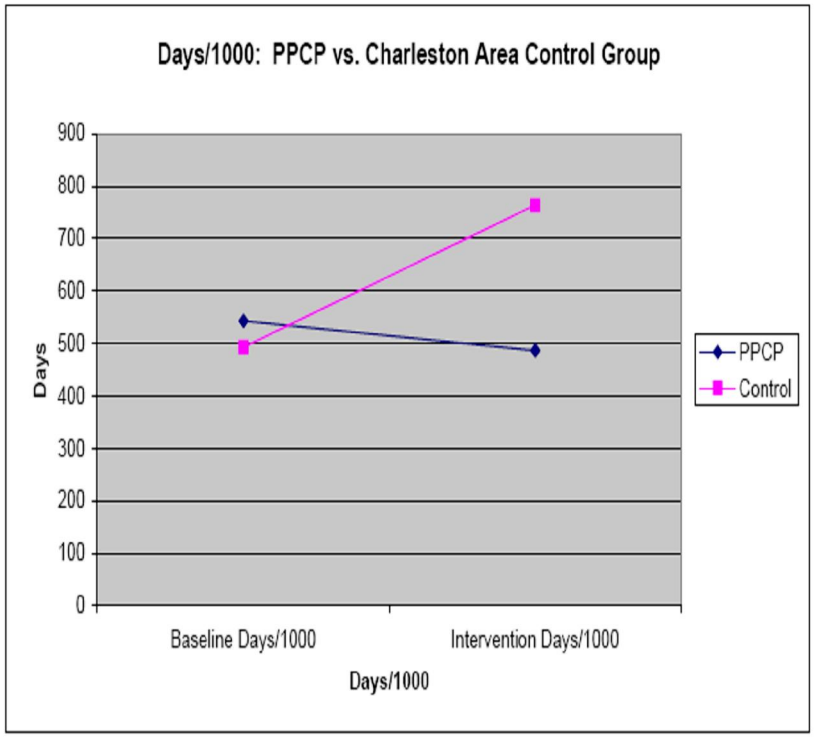
Admissions/1000



- Baseline Year: PPCP admits/1000 7.8 % higher than Control Group
- Intervention Year: PPCP admits/1000 10.7% lower than Control Group

Pilot Group vs. Charleston Area Control Group

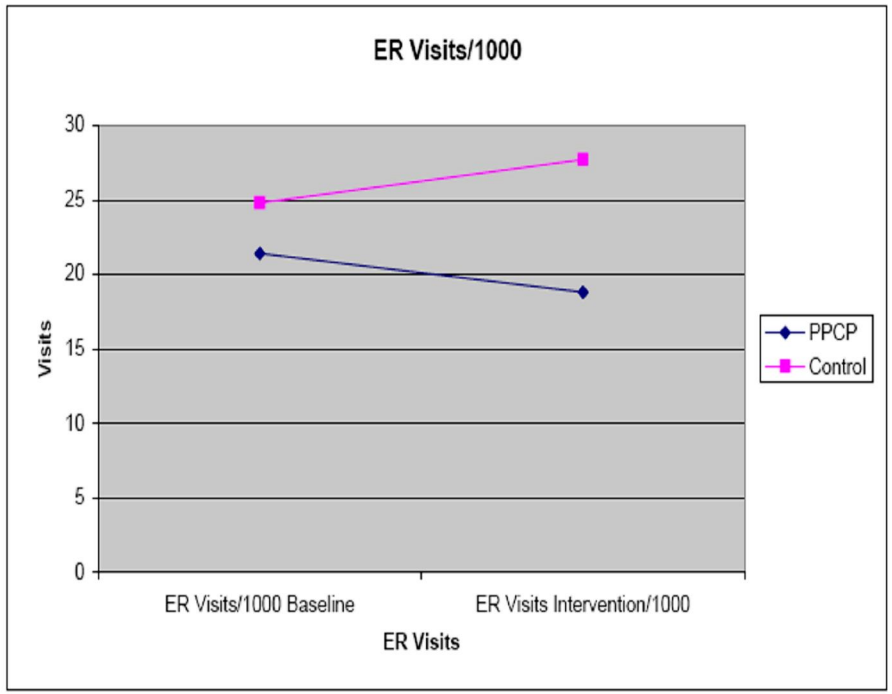
Hospital Days/1000



- Baseline Year: PPCP days/1000 10.3 % higher than Control Group
- Intervention Year: PPCP days/1000 36.3% lower than Control Group

Pilot Group vs. Charleston Area Control Group

ER Visits/1000



- Baseline Year: PPCP ER visits/1000 13.7% lower than Control Group
- Intervention Year: PPCP ER visits/1000 32.2% lower than Control Group

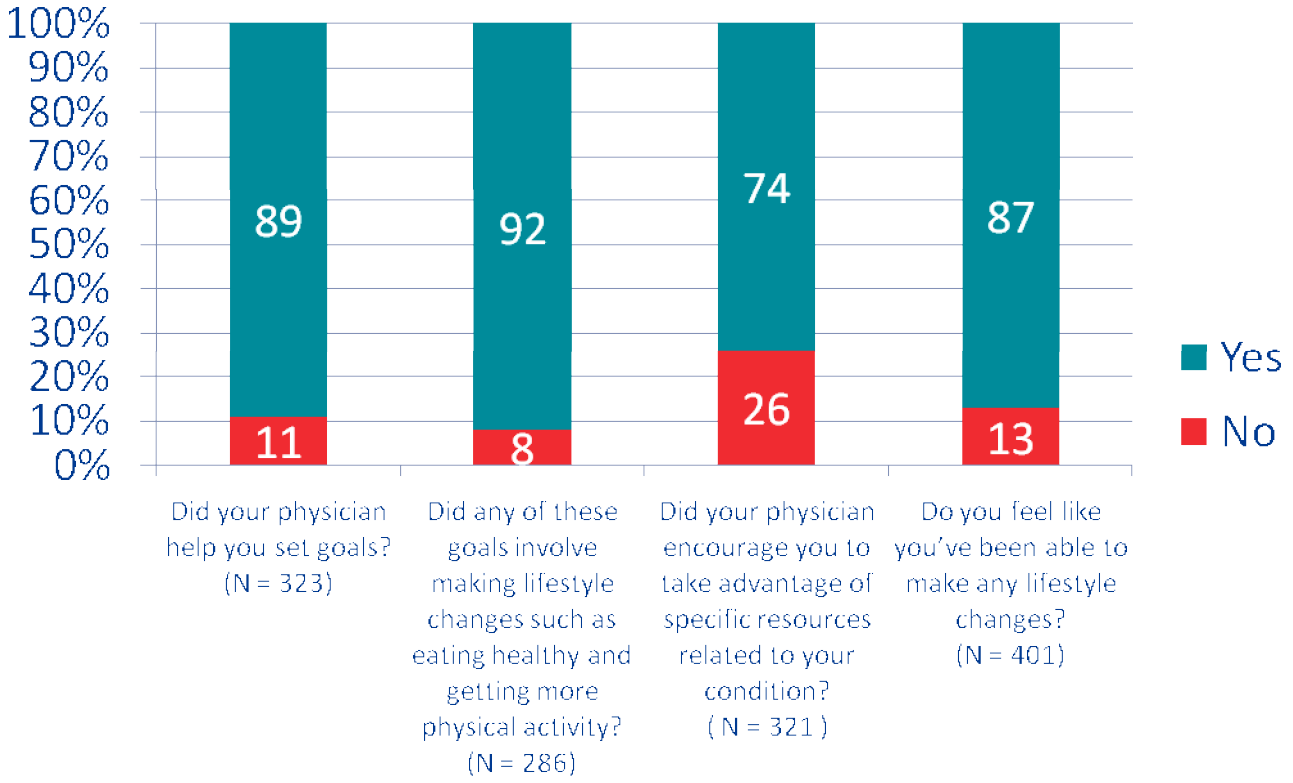
Initial Pilot Financial Impact

Pilot Group vs. Charleston Area Control Group

PMPM Pilot v. Control Costs	Percentage Variance
Baseline	(0%)
Intervention	(6.5%)

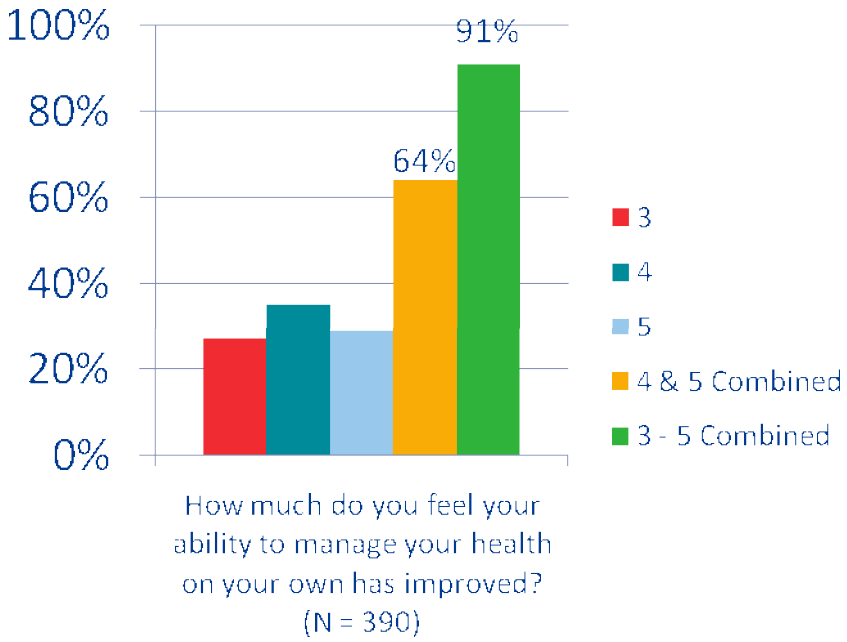
Medical Home Patient Survey – Physician / Patient Engagement

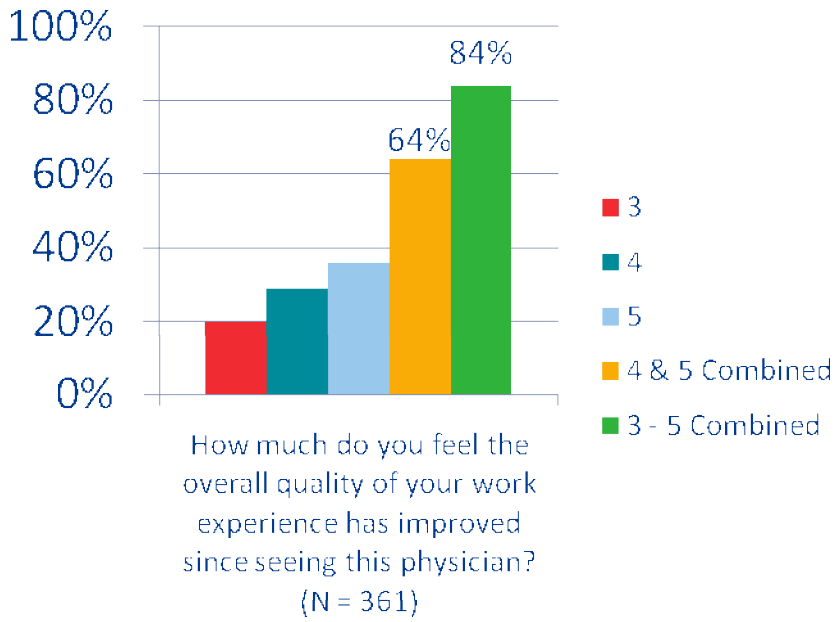
Assessment Questions



Medical Home Patient Survey – Physician / Patient Engagement

Assessment Questions

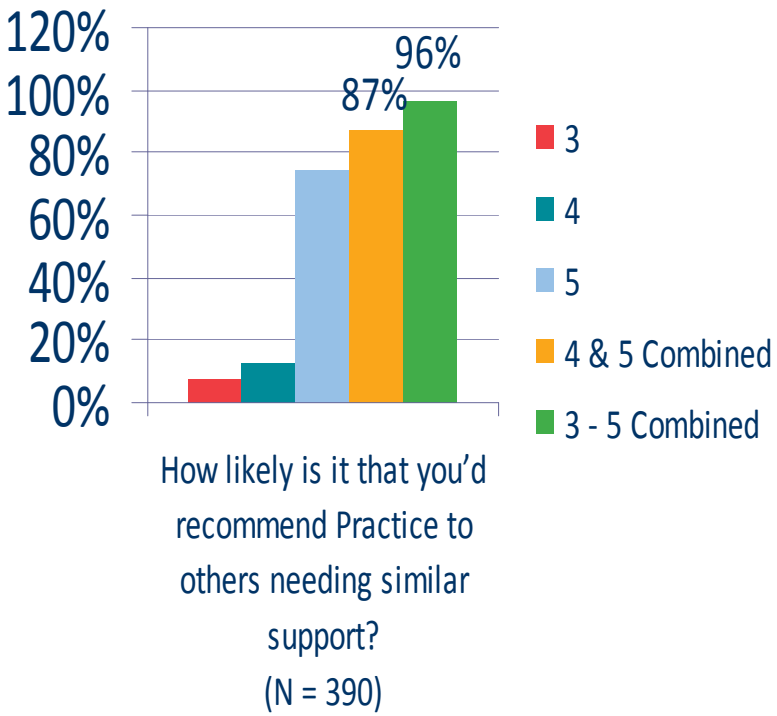


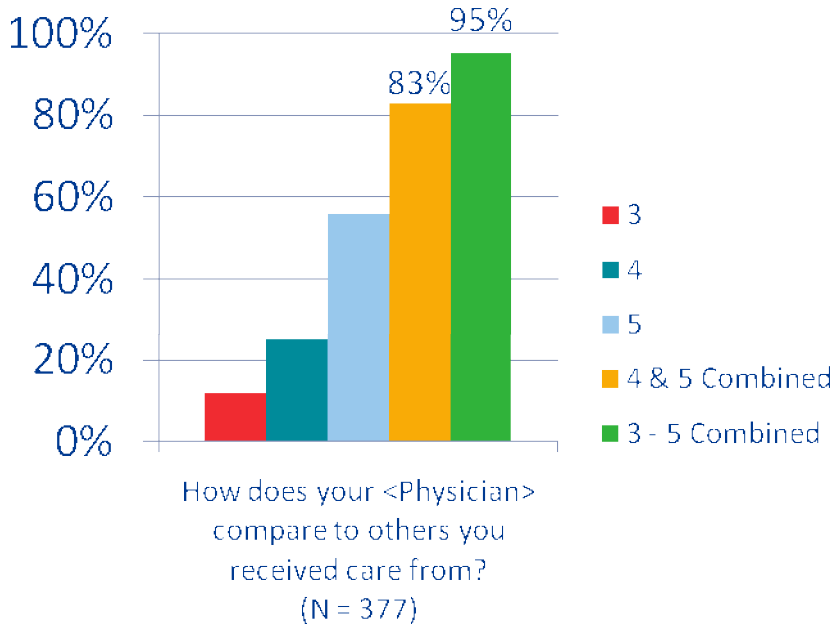


Survey Question Based on 5-point scale
N = Total number of members answering question

Medical Home Patient Survey – Overall Experience Assessment

Sample Questions





Survey Question Based on 5-point scale
N = Total number of members answering question

Medical Home Pilots – 2010

- University of South Carolina Department of Family Medicine pilot.
  - launched July 1, 2010
  - targets approximately 250 patients with diabetes and/or heart failure.

- Achieved Level III NCQA PCMH accreditation.
  - Onsite PharmD focusing on medication management and adherence
  - Home visits for high-risk patients discharged from hospital

Medical Home Pilots – 2010

- Mackey Family Practice
  - » A rural primary care practice in Lancaster, S.C.
  - » Launched October 1, 2010
  - » Targets approximately 300 patients with diabetes and heart failure.
  - » Practice had obtained Level III NCQA PCMH accreditation prior to pilot start date.
  - » Will integrate behavioral health as component of medical home:
    - Å Screen all PCMH members for depression/anxiety
    - Å Reimburse on-site behavioral health care practitioner visits

Medical Home Pilot – 2011

- Broad engagement of physician practices across South Carolina
- Expand clinical conditions and health populations
- Engage employers and government payers in expansion strategy
- Seed/share best practices across state
- Collaborate in development of Accountable Care Organizations (ACOs) and coordinate with PCMH networks

Criteria for Participation

- Demonstrated readiness for practice transformation to an effective patient centered medical home practice
  - » Eligible practices must seek and obtain at least Level I NCQA PPC-PCMH accreditation within six months of contract execution and level II NCQA PPC-PCMH accreditation within 18 months.
  - » Committed physician leadership
  - » Committed practice management/administrative staff
  - » A sufficient number of BlueCross and BlueShield of South Carolina and BlueChoice patients with targeted conditions.

BCBSSC Model for PCMH

- Assessment of practice readiness
- Assistance with Resources
  - » Pharmaceutical and DME vendors with practice tools/resources to assist practice with NCQA Recognitions for Diabetes, Heart/Stroke and Patient Centered Medical Home
  - » Assistance with identifying other resources needed to assist practice with PCMH domains: Care Coordination, Team-Based Approach, Patient Self-Management, Electronic Connectivity, Expanded Access
  - » Development of PCMH Manual

BCBSSC Model for PCMH (continued)

- Promote Team-Based approach to care and disease management. Health Plan care management and disease management staff will work with practice staff to engage members in self-management programs/activities.
- Offer Reimbursement Methodology that rewards for attributes of effective PCMH practice
- Provide training sessions/sharing of best practices as additional pilots are implemented.

Initial Pilot Lessons Learned

- Access to “real-time” clinical data enhances collaboration related to patient outreach and care coordination.
- Effective patient education materials are critical to success.
- Pharmaceutical and DME company vouchers are excellent resources for engaging patients.
- Diabetic education and medication management can be key to patient compliance and help improve outcomes.
- Patient deductibles, coinsurance and copayments can serve as barriers to patient compliance.
- There is an ongoing need to assess and reassess which interventions and tools add value.
- Transformation to Medical Home is time and resource intensive.

Tips for Improving Outcomes

- Engage Your Physician Partners
- Establish meaningful measures for plan, practice and impacted members.
- Use nationally recognized treatment goals.
- Establish patient baseline.
- Set realistic improvement goals using baseline for each measure.
- Share data and discuss changes quarterly.
- Assist practice in identifying patient engagement tools and resources to further improve outcomes.
- Connect onsite care coordinators with plan Health Coaches in order to coordinate efforts.
- Compare outcomes to baselines for continuously enrolled population.

Meaningful Use

American Recovery and Reinvestment Act (ARRA) of 2009: Meaningful Use of Electronic Health Record (EHR)

- President Obama signed the ARRA in February 2009
  - » Approximately $34 billion in Entitlement Funds dedicated to Medicare and Medicaid as incentives for physicians and hospitals who purchase and use EHRs
  - » Bonus payments will be made to “Meaningful Users” of qualified EHRs.
    - Å Defined by the Office of the National Coordinator for Medicare which falls under HHS. Defined by the state and approved by CMS for Medicaid.

Health IT & Transformed Health Care

Department of Health & Human Services
Office of the National Coordinator for Health Information Technology

- Ultimate vision is to enable significant and measurable improvements in population health through a transformed health care delivery system.
- Key goals*:
  - Improve quality, safety, & efficiency
  - Engage patients & their families
  - Improve care coordination
  - Improve population and public health; reduce disparities
  - Ensure privacy and security protections

*Adapted from National Priorities Partnership. National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare. Washington, DC: National Quality Forum; 2008

Health Information Technology for Economic and Clinical Health (HITECH) Act

Payments for Meaningful Use of Certified EHR from 2011 – 2015.
Disincentives after 2015

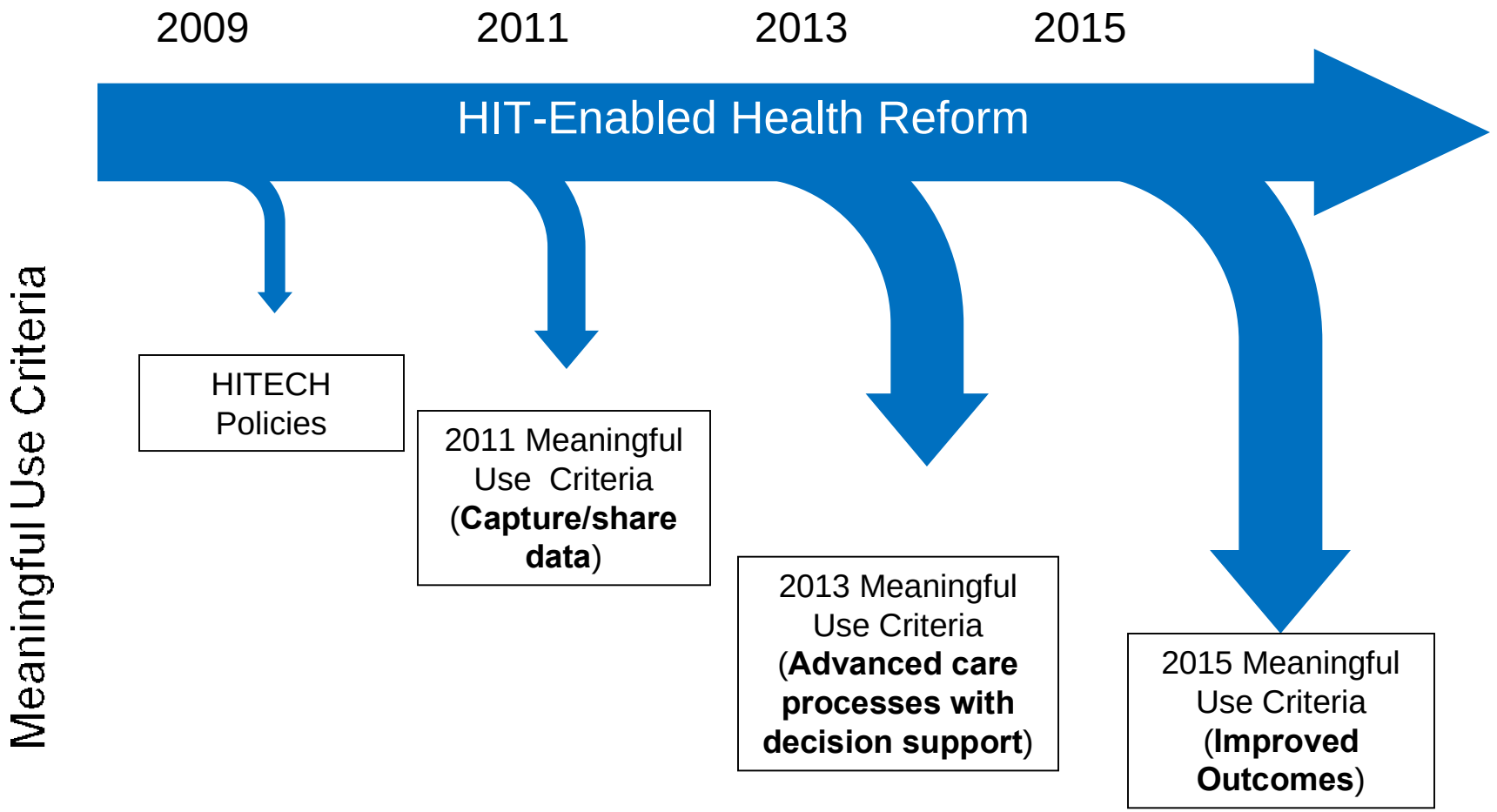
- Medicaid Providers (up to $63,750 per provider)
  1. Based on Medicaid Patient Volume
  2. MD, DO, DDS, NP, CNM & PAs with exceptions

OR

- Medicare Providers (up to $44,000 per provider)
  1. Based on % of allowable charges
  2. MD, DO

HIT-Enabled Health Reform

Department of Health & Human Services
Office of the National Coordinator for Health Information Technology



Incentive Payments Eligibility:

- The eligible professional must meet the Medicaid or Medicare program requirements

- The EHR system being adopted and used by the eligible professional MUST meet federal certification standards.

- And… the provider must demonstrate or attest to using specific functions of the EHR required in the Meaningful Use final rule.

Meaningful Use Requirements

- Generate and transmit prescriptions electronically
- Record demographics on language, gender, race, DOB etc
- Maintain up-to-date problem list
- Maintain active med list
- Maintain active med allergy list
- Record and chart changes in VS, BMI, growth charts for kids
- Record smoking status
- Implement one CDS rule and track compliance
- Report clinical quality measures to CMS

- Stage 1-40%, 2-60%, 3-90%
- Stage 1-50%, 2-80%, 3-90%
- Stage 1 80% have one entry, 2-80%, 3- lists are up to date
- Stage 1-80% have one entry, 2 & 3-80%
- Stage 1-80% have one entry
- Stage 1-50% ht, wt and BP, 2 & 3-80%
- Stage 1-50%, 2&3-90%
- Stage 1-Implement, 2&3-improve performance
- Stage 1-Attest, 2-electronically

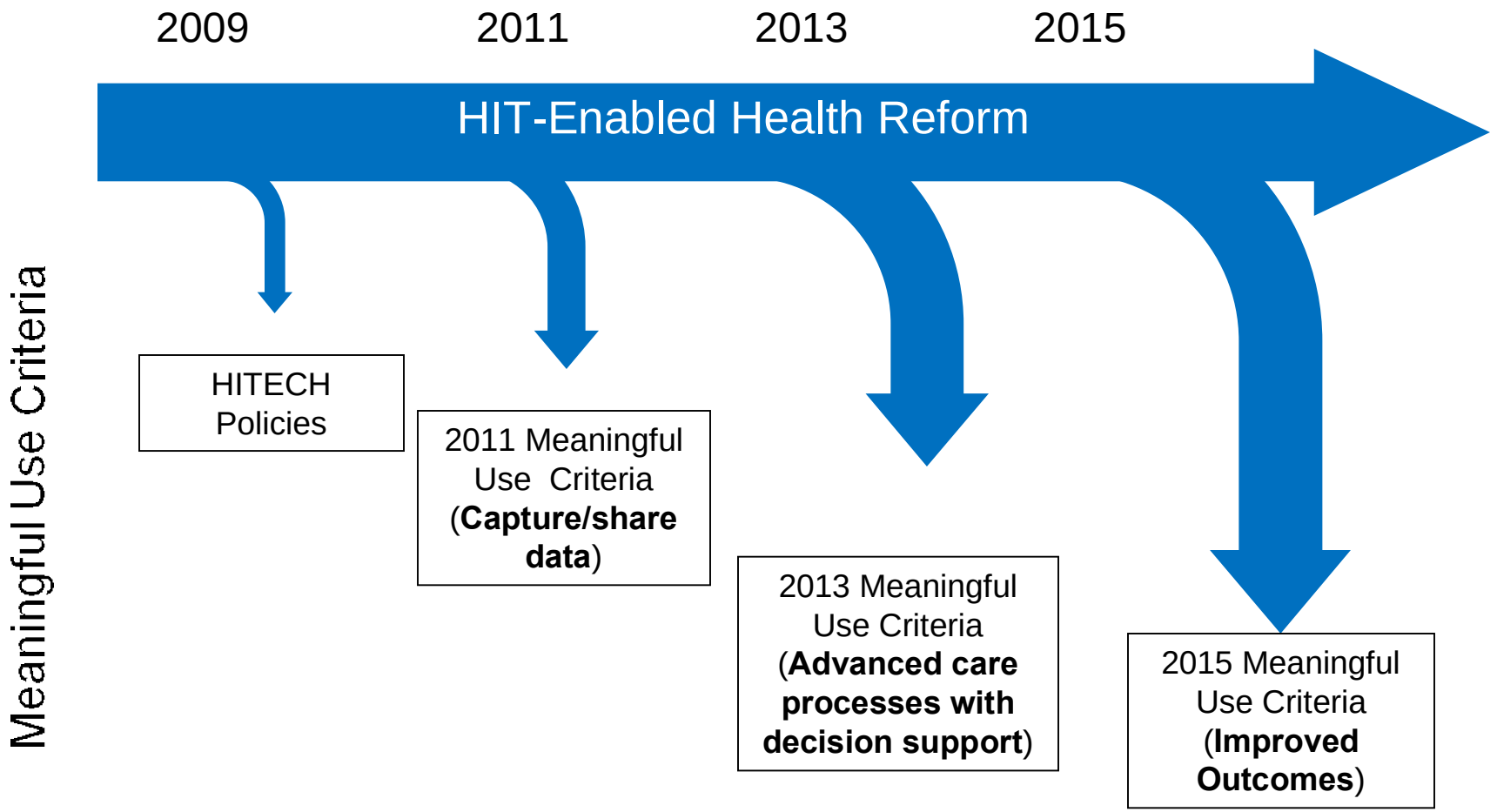
Meaningful Use Requirements

- Provide clinical visit summaries to patients
- Capability to exchange key clinical information among providers electronically
- Protect electronic health info created or maintained by EHR
- Use CPOE for med orders
- Implement drug-drug and drug-allergy interaction checks

- Stage 1-50% within 3 days, 2-within 24 hours, 3-structured form
- Stage 1-Perform one test of exchange capacity, 2-connect to 3 providers, 3-30% of primary care providers
- Stage 1-security risk analysis, 2-add lab and radiology
- Stage 1-30% of patients with at least one med, 2-60%, 3-80%
- Stage 1 enabled technology, 2-checks evidence based, 3-add drug-lab checks

HIT-Enabled Health Reform

Department of Health & Human Services
Office of the National Coordinator for Health Information Technology



NCQA's Patient-Centered Medical Home (PCMH) 2011

- The 2011 program aligns closely with many specific elements of the federal program that rewards clinicians for using health information technology to improve quality (CMS's Meaningful Use Requirements)

- The PCMH 2011 Standards:
  - » Enhance Access and Continuity
  - » Identify and Manage Patient Populations
  - » Plan and Manage Care
  - » Provide Self-Care and Community Support
  - » Track and Coordinate Care
  - » Measure and Improve Performance
- Download standards free of charge at www.ncqa.org/view-pcmh2011. Appendix contains meaningful use and PCMH crosswalk

NCQA 20ll and Meaningful Use

Enhance Access/Continuity	▪Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours ▪The practice provides electronic access ▪Patients may select a clinician ▪The focus is on team-based care with trained staff
Identify/Manage Patient Populations	▪The practice collects demographic and clinical data for population management ▪The practice assesses and documents patient risk factors ▪The practice identifies patients for proactive and point-of-care reminders
Plan/Manage Care	▪The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems ▪Care management emphasizes: »Pre-visit planning »Assessing patient progress toward treatment goals »Addressing patient barriers to treatment goals ▪The practice reconciles patient medications at visits and post-hospitalization ▪The practice uses e-prescribing

NCQA 20ll and Meaningful Use

Provide Self-Care Support/Community Resources	▪The practice assesses patient/family self-management abilities. ▪The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources ▪Practice clinicians counsel patients on health behaviors ▪The practice assesses and provides or arranges for mental health/substance abuse treatment ▪The practice uses EHR to identify patient-specific education resources and provide to patients
Track/Coordinate Care	▪The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g. hospitals) ▪The practice follows-up with discharged patients ▪Electronically incorporate clinical lab test results into structured fields in the medical record ▪Demonstrating capacity for electronic exchange of key clinical information between clinicians ▪Providing an electronic summary of care record for referrals
Measure/Improve Performance	▪The practice uses performance and patient experience data to continuously improve ▪The practice tracks utilization measures such as rates of hospitalizations and ER visits ▪The practice identifies vulnerable patient populations ▪The practice demonstrates improved performance. ▪The practice electronically reports 1) Ambulatory clinical quality measures to CMS, 2) Data to immunization registries or systems, 3) Surveillance data to public health agencies

Questions